Symmetrical Gangrene was first described by Raynaud in 1862. It is rare in the severe form, but not uncommon in the milder. It affects the last phalanges of the fingers and toes, and less often the tip of the nose and the ears. The part becomes white, cold, numb and tingling. This lasts for a time, then passes off and constitutes the so-called dead finger or toe. Instead of returning to the normal the part may become dry, scaly and atrophied, or bullæ may form with sloughing, gangrene and loss of the part. Recurrences are apt to take place.

The disease is neurotic in origin, influenced by the existence of gout, or malaria, and provoked by exposure to cold. It occurs at any age and in men rather than women.

The *treatment* is that of the underlying cause. Galvanism is indicated. If sloughing take place the treatment is on surgical principles.

Fig. 25.—Dermatitis Congelationis with Gangrene (Ohmann-Dumesnil).

Dermatitis Gangrenosa Infantum. This is the term applied by Radcliffe Crocker to a gangrenous affection of the skin, following the pustular dermatoses and the eruptive fevers, especially varicella. When it occurs during varicella one or several vesicles become converted into blebs or dark, peripherally enlarging crusts. Necrosis takes place, giving rise to deep, punched-out ulcers which discharge freely. If the gangrenous process be extensive, marked constitutional symptoms supervene and in feeble and debilitated children death is apt to ensue.

Pulmonary infarctions are common, and many of the children are the subjects of acute tuberculosis. The disease is probably of bacterial origin. In case of recovery considerable scarring remains.

The treatment is supportive, and locally antiseptic applications are to be made

Dermatitis Exfoliativa. Exfoliative dermatitis is an acute affection

of the skin, accompanied by more or less generalized erythematous inflammation with free exfoliation or desquamation during the course of the disease, or subsequent to it. It may be developed suddenly without apparent cause, or gradually from an already existing dermatosis. Constitutional symptoms are generally present and vary in severity with the extent of the eruption. The disease tends to run its course in a month or six weeks, but exhibits a marked disposition to relapse and recur. The desquamation which is the salient feature of the disease may consist of fine, dry, papery scales, or large pieces of skin may be detached, especially from the palms and soles. The nails are sometimes shed, and the hair much thinned. Itching and burning are present to a greater or less extent.

The disease is distinctly rare.

There is a variety of exfoliative dermatitis which occurs in infants, and runs a rapid and often fatal course. It begins as redness and fissuring about the mouth, and spreads to involve more or less of the entire surface of the skin. It is accompanied by free desquamation, and when moist resembles eczema.

Pityriasis rubra is sometimes described under the head of *dermatitis exfoliativa* but deserves a special notice.

Treatment. The treatment is internal and local. The internal treatment consists in the administration of reconstructives, and tonics, and concentrated nourishment. Crocker recommends quinine. Diuretics and saline aperients are indicated. In severe cases the patients should be kept in bed. Local treatment consists in the use of bland ointments, such as oxide of zinc, and oily applications as carron oil, or of calamine and lime water.

DERMATITIS BLASTOMYCETICA.

Definition and Description. Blastomycetic dermatitis is a rare and chronic disease due to the *blastomyces* or yeast fungus. Its characteristic features are the development from a nodule situated upon the hands, face, feet, thigh, scrotum or back, of a slowly growing, verrucous patch studded with minute abscesses.

Blastomycetic dermatitis resembles *tuberculosis verrucosus cutis* and the tubercular syphilide, but is usually multiple, or becomes so. The fungus may be found in the miliary abscesses.

Treatment. Antiseptic and parasiticidal remedies are to be used locally. Erasion with the curette is the speediest and most reliable method of treatment. Internally, potassium iodide exercises a decidedly beneficial effect upon the lesions. The disease offers a legitimate field for use of the X-rays and the Finsen light.

DERMATITIS HERPETIFORMIS.

Synonym: Duhring's Disease.

Definition. *Dermatitis herpetiformis* is a chronic, relapsing disease of the skin characterized by a complexity of lesions consisting of macules,

superficial erythematous patches, papules, pustules, vesicles, bullæ, or wheals, accompanied by considerable itching and burning, and slight constitutional symptoms. The disease is rather rare, and was first described by Duhring, of Philadelphia.

Symptoms. Slight constitutional symptoms, constipation and moderate fever precede the attack. One of the primary efflorescences may characterize the outbreak, or it may occur in a riot of forms. Multiformity and herpetiformity are the salient features of the disease. It runs a chronic course with varying intermissions.

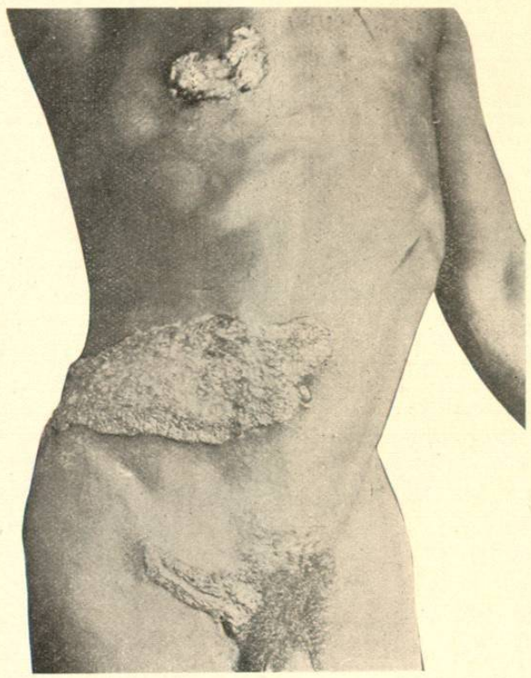

Fig. 26.—Dermatitis Blastomycetica (T. C. Gilchrist).

The eruption is usually symmetrical, and commonly appears on the flexor surfaces of the forearms, chest, abdomen, buttocks and outer aspects of the thighs. The mucous membranes may be affected. Special types of the disease, while rarely persistent are as follows:

Erythematous, characterized by more or less circumscribed redness, which resembles erythema multiforme and undergoes changes in hue. The erythema occurs in crops.

Vesicular. This form is most commonly present. The vesicles are plump, pin-head to a pea sized, clear or yellowish and occur in groups with or without erythematous bases. They do not tend to rupture and may

run together as in herpes zoster. The itching is usually severe until the vesicles are broken, when it is abated. Blebs are formed by fusion of vesicles and occur in clusters surrounded by small pustules or vesicles.

Pustular. This form is not usual, and is more persistent than the foregoing types. The pustules are primary, and, like the vesicles, may be large or small.

Papular. The papular type is the mildest and most uncommon. The papules tend to become vesicular at their summits.

Mixed or Multiform type. This variety shows a general intermingling

Fig. 27.—Dermatitis Blastomycetica (Gilchrist).

of the primary forms with the addition of excoriations, blood crusts and pigmentation.

Etiology. Dermatitis herpetiformis occurs as a rule in adults and is probably dependent upon some disturbance of the nervous system. It has been known to follow severe physical or mental shock. A patient, a young married woman, developed the disease as a consequence of a fall from a horse. Pregnancy, menstrual irregularity, renal insufficiency, are among other contributing causes.

Diagnosis. The multiformity of the lesions with marked herptiform characteristics, the intense itching, the history of chronicity and tendency to recurrence are sufficient to enable one to establish a diagnosis. It is to

be distinguished from impetigo herpetiformis, an exceedingly rare and usually fatal disease of pregnant and puerperal women; from pemphigus

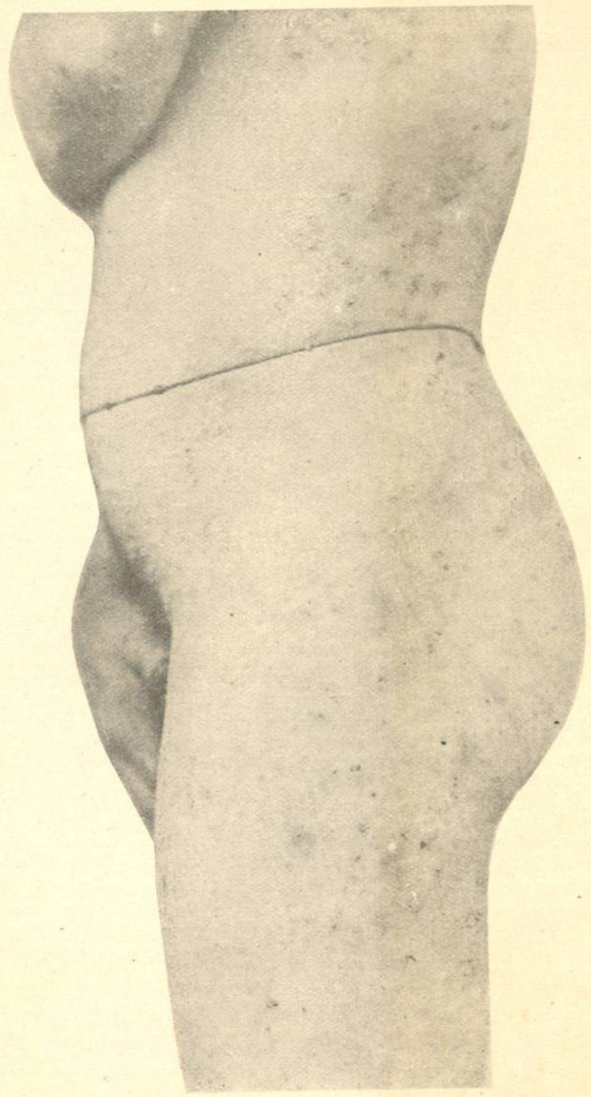

Fig. 28.—Dermatitis Herpetiformis (Dr. Isadore Dyer).

by the primary character and persistency of the blebs of this disease; from eczema and erythema multiforme by the characteristic course of these

affections, the small vesicles of the former and the absence of marked itching in the latter.

Treatment. The treatment of dermatitis herpetiformis consists in endeavoring to relieve the causative condition which usually resides in the nervous system. There are no special indications beyond the use of nerve tonics, iron, quinine, strychnine, and especially arsenic, with concentrated nourishment during the attack. Nerve sedatives, as valerian, cannabis indica, antipyrine or phenacetine may be required to relieve the nerve storm accompany intense itching.

Locally, in the pustular and vesicular types, strong sulphur ointments are recommended; in the erythematous, carbolized oil and lime water, equal parts, ichthyol, two to ten per cent. with olive oil or lime water. *Liquor carbonis detergens*, and ointments of salicylic acid and boric acid are said to be useful. Bullæ should be punctured and the contents evacuated. The lesions on the mucous membranes are treated with nitrate of silver solutions.

Prognosis. The prognosis as to cure is uncertain. Except in rare instances of the bullous or pustular forms, the disease is never fatal. Relapses are the rule.

DERMATITIS PAPILLARIS CAPILLITII.

Definition and Description. This affection is of a mildly inflammatory nature and consists of firm, vascular papules which enlarge, coalesce and form keloidal masses. It affects chiefly the back of the neck near the edge of the hair, and sometimes extends upward upon the scalp. The front of the neck and inframaxillary regions are also affected, but with the smaller form of papules which tend to remain discrete.

When located on the neck there is usually some loss of hair; the beard seems unaffected.

The disease is common in full-blooded negroes but rare in the white race. It developes about the age of puberty, and is very chronic, showing no tendency to spontaneous cure and may remain practically unchanged for years. The smaller papules tend to become flattened with age, and assume an ashen hue.

The cause of the affection is unknown, but the marked tendency to hypertrophy among negroes may be taken as a causative factor.

Treatment. The papules which are in effect miniature keloids may be removed with the knife, electric needle, or destroyed with caustic potash on a tooth-pick. Epilation and the use of a strong sulphur ointment have been recommended. The growths are prone to return after the manner of keloid.

DERMATITIS FROM THE X-RAYS.

Prolonged exposure to the emanations from an excited Crookes' tube, or short exposures frequently repeated, are liable to produce reaction in the skin of a varying degree of intensity and severity. There may be sim-

ply a dusky redness of the exposed part, which persists for a week or ten days, and passes off to leave the skin somewhat tanned. This degree of reaction is frequently designedly brought about, not a few radiologists maintaining that favorable results are not forthcoming until this condition is produced. The reaction may be of considerably higher grade with vesiculation and desquamation. Rarely there is such an impairment of the vitality of the skin as to occasion necrosis with sloughing and ulceration, the ulcers being painful, indolent and very rebellious to treatment. With

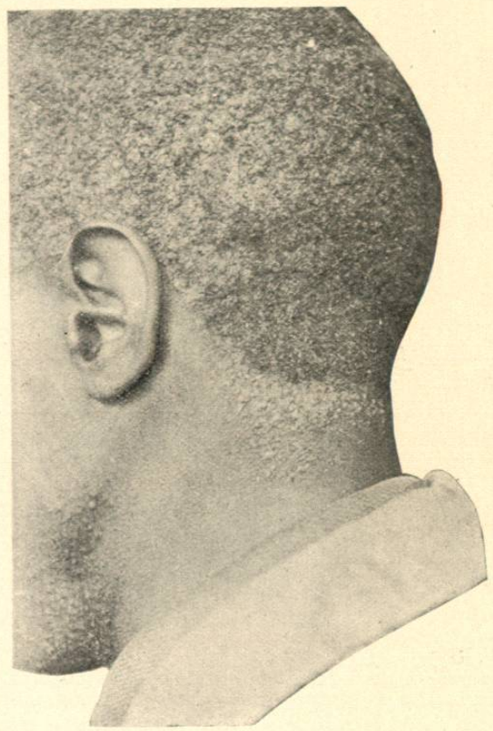

Fig. 29.—Dermatitis Papillaris Capillitii (mild form).

advance in knowledge of the action of the X-rays the severer forms of dermatitis have become much less frequent than at an earlier period of Röntgen therapy. It should be borne in mind that some individuals are more susceptible than others to the influence of the rays and that reaction occasionally occurs some time after exposure to the rays. These facts should beget an abundance of caution in those who are beginning to avail themselves of a most valuable, as well as a most powerful, therapeutic agent.

Treatment. Slight X-ray reaction requires no treatment as it tends to disappear rapidly and spontaneously. Ointment of rose water may be

used if the subjective symptoms cause any annoyance. In the severer grade of reaction, the itching and burning may be alleviated with an ointment of boric acid, or zinc oxide ointment. In the rarer forms of sloughing with ulceration the general principles of surgery apply in the matter of treatment. Static electricity and the high frequency currents give promise of hastening the work of repair.

DERMOLYSIS.

Definition. Dermolysis is a rare congenital anomaly of the skin, characterized by its extreme elasticity from loose subcutaneous attachment. The skin may be grasped in the hand and drawn out a distance of a foot

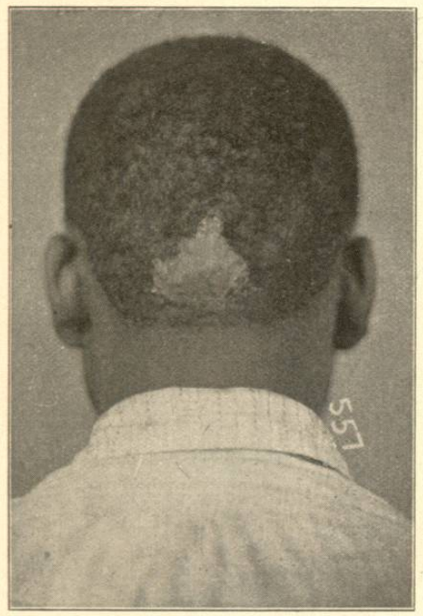

Fig. 30.—Dermatitis Papillaris Capillitii (I. Dyer).

to half-a-yard from the body and on being released returns to a normal position without folds or irregularities. Individuals presenting this peculiarity are sometimes exhibited as side-show freaks under the name of "loose-skin" men. Histologically there is a "transformation of connective tissue of the dermis into unformed tissue like a myxoma, with total disappearance of the connective tissue bundles." The elastic tissue is normal. The condition may be limited to particular regions of the body or the entire skin share in it.

Under the caption dermolysis is sometimes included hypertrophy of

the skin with a tendency to slipping down in folds or pendulous masses, but this condition more properly belongs to fibroma and the term dermolysis is reserved for laxity of the skin without hypertrophy.

DHOBIE ITCH.

Definition. Dhobie itch is the name given to a large number of itching parasitic diseases found in the tropics.

Varieties. Three varieties are distinguished: an eruption resembling erythrasma and due to the *microsporon minutissimum;* a variety apparently identical with ringworm and due to the *trichophyton;* a form distinguished by the presence of pemphigoid vesicles or blebs, and termed by Manson *pemphigus contagiosus,* and according to him also occasioned by a diplococcus.

Symptoms. The eruption may occur anywhere on the body, but usually in the axilla, crotch, soles of the feet and between the toes. It is conveyed by means of clothing, sexual intercourse and bathing in sluggish streams and tanks. The mycotic forms affect the region of the perineum and axilla and resemble ordinary ringworm. From these localities the disease is conveyed to other regions of the body. The margin of the patches is scaly, the patches themselves are slightly raised and present red, shining, glossy centres.

Smarting and itching are often severe. Unless vigorously treated the disease tends to spread and may continue to do so until the advent of cool weather, when it subsides to recur at the next approach of hot weather.

Pemphigus contagiosus occurs as vesicles or blebs which rupture, leaving a red, shining, denuded surface with a surrounding zone of raised epidermis. The eruption may be limited to the axilla or crotch, or may be scattered over the whole body when, if the vesicles are small, it presents a close resemblance to chicken-pox, wanting, however, constitutional symptoms.

Treatment. The treatment should be vigorous. The parts are scrubbed with tincture of green soap and some active parasiticide applied, such as Vlemingkx's solution of the sulphuret of calcium. Oleate of mercury, or chrysarobin, or pyrogallol are recommended, as is also painting the surface with tincture of iodine or salicylic-collodion.

The danger of reinfection is considerable and must be guarded against so far as practicable.

Pemphigus contagiosus is best treated with lotions of bichloride of mercury according to Keiffer (to whom much of this description of dhobie itch is due). Dusting powders are used to keep the parts dry.

DYSIDROSIS.

Synonyms: Cheiro-pompholyx, Pompholyx.

Definition. Dysidrosis consists in an eruption of vesicles or bullæ usually on the hands, more rarely on the feet, and generally associated

with hyperidrosis. The disease may occur at any age, but is seen chiefly in neurotic and debilitated young adults.

Symptoms. The vesicles appear on the palm and sides of the fingers, rarely the entire hand. They are embedded in the skin or slightly raised above it, and are of a grayish, translucent appearance, resembling boiled sago grains. Smarting and itching accompany the eruption. The vesicles remain discrete with little tendency to rupture and are absorbed, or clusters coalesce to form flat or prominent bullæ which are also absorbed, leaving the epidermis covering them to be exfoliated or removed. New lesions appear in crops until the disease begins to subside. There is little or no inflammation accompanying the vesicle formation.

The affection occurs in the spring and autumn with the transition of cold to warm weather, or the reverse.

Etiology. Divergent views are entertained of the nature of the disease. It is held by some to be neurotic in origin, others maintain that the process is local. Unna regards the affection as due to a micro-organism which flourishes in the sweat secretion. The bulk of the evidence seems against its being a disorder of the sweat glands, as its name, which was bestowed by Tilbury Fox, implies.

Diagnosis. Dysidrosis is distinguished from vesicular eczema by its situation, character of the vesicles and course, and from pemphigus by the formation of vesicles not primarily but from fusion of vesicles.

Treatment. General tonics are usually indicated. Arsenic has been strongly recommended.

Locally, applications suitable to acute eczema are advised. The oleates are serviceable, and a ten to twenty per cent. solution of formalin may be used in the mild cases to check the free sweating which usually coexists. A two per cent. solution of salicylic acid in alcohol will be found very useful.

Prognosis. Severe types of the disease are rare; mild are very frequent, and all tend to spontaneous recovery in a few weeks. Seasonal recurrences are common.

ECTHYMA.

Definition and Description. Ecthyma is a cutaneous disease manifested by the appearance of one or several flat, dime-sized, discrete pustules situated upon a markedly inflamed base and surrounded by an areola. The pustules are usually located upon the legs and are at first small, lax and flabby; later, they tend to enlarge, and their contents from being yellowish becomes stained with blood. They finally dry into heavy, brown crusts which, when removed, reveal very superficial ulceration. The pustules occur in crops, new lesions springing up at longer or shorter intervals.

Itching is slight, burning pain and tenderness may be present. Slight scarring with pigmentation may follow healing.

Etiology. Ecthyma is due to pus micro-organisms and occurs chiefly

among the poor, ill-nourished and unwashed of the population. It ensues upon slight abrasions from scratching or other mild traumatism, or from the bites of insects. It is but slightly contagious and is seen chiefly in men.

Diagnosis. Ecthyma is to be distinguished from *impetigo contagiosa* which it closely resembles. It differs from it in being more inflammatory, less auto- and hetero-inoculable, in its occurrence in adult males, and its situation. From *ulcerative pustular syphiloderm* it is distinguished by the deep ulceration, distribution and the more deliberate course of the syphiloderm and the contributory evidences of syphilis.

Treatment. The disease is readily cured by the local use of antiseptics, after the crusts have been removed. The following is effective:

℞

Hydrarg Ammoniat.,	gr. x-xx.
Acid Carbolic.,	gtt. x.
Unguent. Aq. Rosæ ad,	℥j.

M. Fnt. Ung.

Lotions of bichloride of mercury 1:1000, or of boric or carbolic acid are equally good. The part must be kept protected by a bandage from further contamination.

For the general treatment, nutritious food, improvement in personal cleanliness and hygiene, and tonic remedies are required.

ECZEMA.

Synonyms. Tetter, Salt Rheum.

Definition. Eczema is a catarrhal inflammation of the skin, acute or chronic, accompanied by a multiformity of lesions and having as a chief characteristic itching, serous or pustular exudation, desquamation and infiltration.

Eczema is the most frequent of all diseases of the skin, and shows the widest diversity in appearance.

Varieties. According to the predominant type of lesion several forms of eczema are recognized. They are the *erythematous, papular, vesicular* and *pustular.* The disease process ordinarily begins with one or more of these primitive forms but in its course there is a proneness to the intermingling of forms and a termination in one of the secondary clinical conditions.

The most frequently encountered secondary clinical forms are *eczema rubrum, eczema squamosum, eczema fissum* or *rimosum, eczema sclerosum, eczema verrucosum.*

Eczema Erythematosum. Erythematous eczema begins as an itching or burning in one or more places in the skin, which is followed by the appearance of ill-defined, red patches which tend to spread and intermingle. The erythema may be limited to a small area, or it may cover large surfaces.

When it has reached its maximum the skin is either a dusky or a bright red, or mottled and sometimes even violaceous. Later it becomes dry, rough, slightly scaly and has a thickened, swollen appearance.

Its favorite seats are the face, forehead, between the eyebrows especially, the genital organs and the flexures of the joints. When occurring under pendulous breasts, between the scrotum and thigh, or in the folds of skin in babies and fat people, it has received the special appellation of *intertrigo.*

Erythematous eczema may remain considerably thickened, lined and scaly (*eczema squamosum*), or pass into the moist, crusted form (*eczema rubrum*).

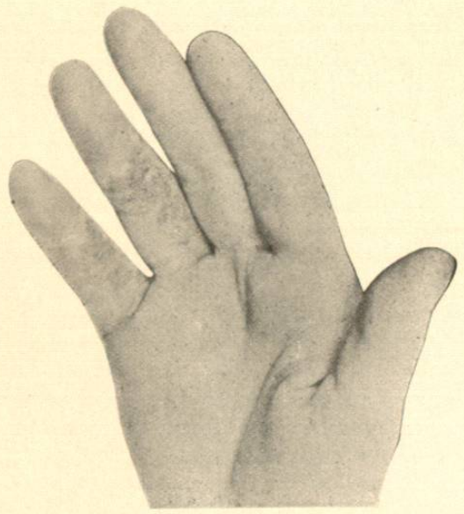

Fig. 31.—Eczema of Digits.

Eczema Papulosum. In papular eczema the papules are small, discrete or thickly set, flat, round or acuminate and usually of a reddish tinge. They show a decided predilection for the extremities.

The lesions are intensely pruriginous, and are frequently capped with a small vesicle. When closely assembled the papules form large or small patches, and the primary lesions finally melting into the mass by reason of the obliterating effect of scratching provoked by the intense itching, show numerous small excoriations and blood crusts. Vesicles are seen scattered among the papules.

This form of eczema is troublesome, refractory to treatment and prone to relapse. This is probably due to the intensity of the itching, very small papules giving rise to astonishingly acute and severe itching.

Eczema Vesiculosum. This is the most frequent type of the disease, and one to which formerly the term eczema was exclusively applied.

Burning or a feeling of heat are the usual precursors of an outbreak of acute vesicular eczema. The skin is somewhat reddened, and the vesicles vary in size and depth of situation with the locality affected. They are usually small, the size of a pin-head or less, agminate, thin-walled, soon become confluent and rupture, the contained fluid drying in crusts. When crowded closely together and broken the appearance is that of a red patch picked out with numerous small pits, each containing a droplet of sticky fluid which stiffens linen and is characteristic of the disease.

The process is acute; the itching intense and paroxysmal. Rupture of the vesicles somewhat relieves the itching, but it recurs as the vesicles reform.

This form of eczema is apt to pass quickly into one of the secondary clinical conditions as *eczema rubrum* or *eczema squamosum*, or assume the pustular phase from invasion of the vesicles with pus micro-organisms.

When there is no distinct vesicle formation but the epidermis is raised up by the pressure of serum and exposes a raw, oozing surface the condition is termed *eczema madidans.*

Vesicular eczema occurs principally on the faces of infants and young children and upon the hands and feet of adults.

Eczema Pustulosum. This variety is often found upon the hairy regions of the body, especially the scalp in children, the presence of hair favoring the harboring of the micrococci of suppuration. A few pustules are, however, commonly associated with all varieties of eczema.

Pustular eczema is primarily pustular, or represents the pustulation of vesicles. The pustules readily rupture, their secretion drying into dirty brown, greenish or yellowish crusts, the exudation imprisoned beneath soon decomposes and gives rise to a disagreeable odor.

The itching is much less than in other varieties of eczema.

Eczema Rubrum represents a clinical condition which results from alterations in one or more of the primary lesions of the disease. The favorite sites of eczema rubrum are upon the scalp and face of children, the legs of middle-aged, stout people, at the flexures of the joints and beneath overhanging folds of skin. The surface is red, raw, oozing and denuded or crusted.

Swelling and infiltration are present. Subjectively there is burning and itching.

Eczema Squamosum. This secondary clinical form commonly proceeds from a foregoing erythematous or papular eczema. It is characterized by reddened, infiltrated, scaly patches, the scales representing the abortive effort at regeneration of the horny layer. They are small, thin and non-adherent. Erythema coexists.

When squamous eczema occurs about the joints or near the orifices of the body where motion is free and more or less constant, the infiltrated skin loses its elasticity and cracks. This is observed about the lips, anus, fingers and palm. Chapping is produced in the same manner. The condition thus brought about has received the name of *eczema fissum* or *rimosum.*

Eczema Sclerosum. This type is usually seen on the palms and soles. The skin is thickened, hard, inelastic and approaches horn in consistence.

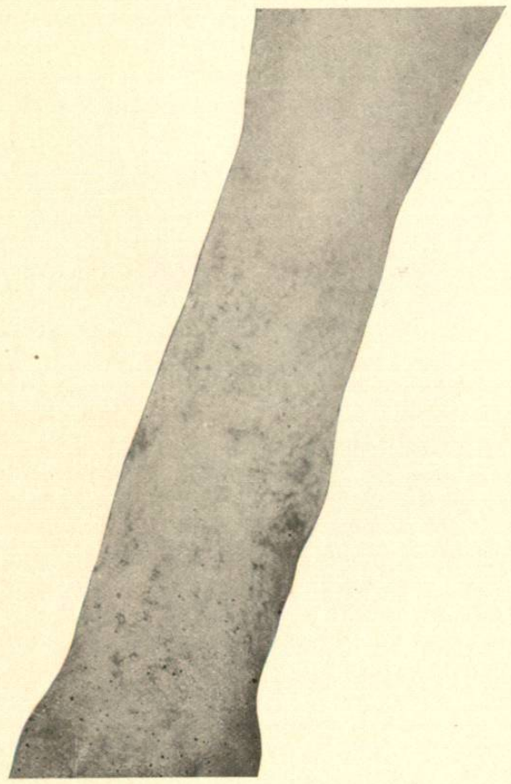

Fig. 32.—Papulo-Squamous Eczema.

It displays but little inflammatory reaction and is quite refractory to treatment.

Eczema Verrucosum occurs as hard, warty elevations usually on the dorsum of the fingers and on the inner side of the index finger. There is sometimes an ill-smelling discharge which issues from between the clusters of hypertrophied papillæ.

Symptoms and Course. Eczema may be either acute or chronic. The term chronic has no reference to the length of duration of the dis-

ease but to the pathological condition, usually infiltration, which is present. A chronic eczema may at any time become acute.

Itching is the most constant symptom of the disease. It varies in intensity and is more or less intermittent and spasmodic.

There are few or no constitutional symptoms of eczema unless such as are occasioned by the circumstance of loss of sleep from itching.

Patches of eczema are usually ill-defined, fading gradually into the surrounding skin and offering a feature of differentiation from the sharp circumscription of certain parasitic affections.

The disease is influenced by season and meteorological conditions. It is aggravated by exposure to cold and wind and sea air.

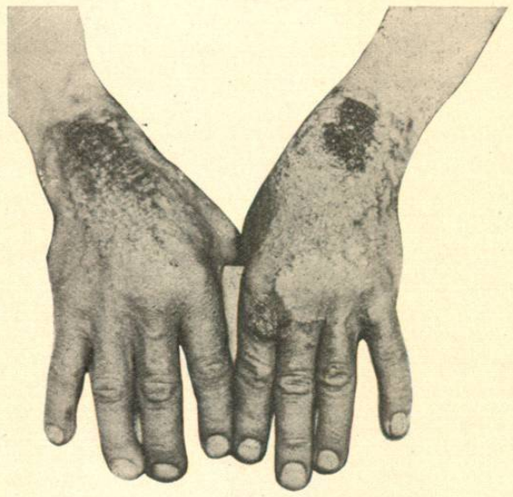

Fig. 33.—Eczema Verrucosum (Unna).

The duration of eczema is in the highest degree uncertain and cannot be forecasted. It manifests but little tendency to spontaneous disappearance.

Etiology. The causes of eczema are constitutional and local, or both combined. It is not contagious nor in a strict sense hereditary, though a dermal quality that seems to offer feeble resistance to the occurrence of eczema may be transmitted through many generations.

Constitutional Causes. The gouty or rheumatic diathesis is an undoubted cause of eczema, although the ever-changing theories regarding uric acid have as yet failed to supply an explanation of the connection which is entirely satisfactory. Constipation, dyspepsia, deficient renal elimination, functional disorders of the nervous system, diabetes, albuminuria and debility, struma, dentition, pregnancy and uterine disease, may be among the factors which are, in a measure, responsible for eczema.

Local Causes. Any irritant, mechanical, thermal, chemical or parasitic, sufficient to produce a dermatitis, may also cause eczema. Scratching, strong soap, strong acids, dye-stuffs, poisonous plants, extremes of heat and cold, parasites, physiological or pathological secretions, are among the most frequent sources of irritation which are competent to call forth an eczema.

Pathology. The process is one of inflammation of varying intensity. The changes begin in the upper part of the corium and epidermis and only in inveterate cases extend into the subcutaneous tissue. The papillæ are hypertrophied and frequently elongated by a downgrowth of the interpapillary portion of the prickle layer. The bloodvessels are dilated, with the production of cellular œdema and infiltration. Parenchymatous œdema of the cells prevents proper keratinization of the horny layer, and as a result the cells retain some of their moisture (*parakeratosis*, of Unna) and cohere in the form of scales. Hyperplasia of the prickle layer produces the papular elements (*acanthosis*), or the cells are pushed apart, their prickles forming a network which becomes soaked with fluid, gradually rising to the surface as weeping or oozing. In the construction of a vesicle the horny layer constitutes the roof and the rete cells are flattened by pressure of the fluid. In eczema rubrum this layer is raised off exposing the *stratum mucosum*, partly denuded, partly crusted or entirely concealed beneath crusts.

Diagnosis. The diagnosis of eczema is, as a rule, easy, although the protean character of the disease is capable of producing perplexity. There are certain cardinal features which if held in mind will materially assist in removing diagnostic difficulties.

Symmetrical distribution, swelling and œdema, exudation of albuminous fluid, infiltration, poor definition of the patches, polymorphism of the lesions, and, subjectively, itching, make up a symptom-complex that should prevent eczema from being confounded with another affection.

The specific points of difference between eczema and certain common affections, which in some of its phases it may resemble, may be briefly considered.

Erysipelas may be mistaken for eczema, but is to be distinguished from it by being essentially acute, frequently beginning from a small abrasion. The patches of erysipelas are smooth, tense, glazed, dusky-red, sharply-defined and painful. There is considerable œdema and swelling, with discrete vesicles and bullæ. Constitutional symptoms (chill, fever) begin early and may be severe.

Psoriasis is diagnosticated from squamous eczema by its dry, sharply-circumscribed, round or oval patches, covered with adherent, papery, silvery scales. Itching is inconspicuous. Psoriasis shows predilection for the scalp, knees and elbows.

Tinea Circinata. Ringworm of the body presents marginate, usually

circular patches which clear in the centre and extend peripherally. Itching is slight and the diagnosis may be fixed by the discovery of the trichophyton in the scales. Disseminated ringworm of the scalp is often difficult to distinguish from a scaly seborrhœic eczema without the aid of the microscope.

Sycosis may be confounded with pustular eczema. Sycosis is a disease of the bearded face and begins in the hair follicles. The pustules are discrete, flat, rupture with some difficulty and are pierced by hairs. The skin is livid or lurid red and small, deep-seated cutaneous abscesses are sometimes seen. Sycosis is also very rebellious to treatment and displays a marked tendency to recur.

Impetigo contagiosa differs from eczema in that it is contagious, begins as a flabby, discrete vesicle or bulla, springing from a slightly inflamed base. The roof of the vesicle or bulla partially slips off disclosing a shallow, raw floor which is quickly covered with loosely adherent, dark crusts. Itching is very slight. It is readily curable under treatment with antiseptics.

Herpes zoster has a slight resemblance to vesiculo-pustular eczema but the grouping of the vesicles in the former affection, their distribution and the precursory and actual pain will serve to establish its identity.

Scabies closely resembles vesiculo-pustular eczema and in fact the two may coexist when vigorous treatment has failed to entirely subdue the itch, but has in addition engendered an eczema from irritation. The general picture of scabies, its location, the linear arrangement of vesicles and pustules, the nocturnal character of the itching, should lead to a correct diagnosis, while the discovery of the acarus in the cuniculi puts it beyond doubt.

Treatment. The treatment of eczema is both general and local. In the former instance the cause should be reached and, if possible, removed. Failing in this only the most general rules apply. Tonics such as quinine, iron, arsenic and nux vomica, the reconstructives, as cod liver oil and the malt preparations, are in frequent requisition. Alkaline diuretics and the free drinking of water are beneficial. The tonic diuretic Basham's mixture is valuable especially in children. Malcolm Morris recommends wine of antimony during the acute stage of the disease, and an emulsion of turpentine during the same period is suggested by Crocker.

Laxatives are often demanded for the relief of constipation. The following is serviceable for atonic dyspepsia with constipation (Schamberg):

℞

Tinct. Nucis Vomicæ,	
Acid. Hydrochloric. Dilut.,	āā ℥ss.
Fluidextract. Cascaræ Sagrad.,	
Tinct. Cardamom. Co. āā q. s.,	ad ℥iij.

M. Sig. Teaspoonful three times a day after meals.

Tincture of *viola tricolor* (pansy) and extract of *rumex* root have been highly praised in the treatment of eczema, though the results obtained seem scarcely to measure up to specifications.

Arsenic is directly beneficial only in such chronic conditions as squamous and papular eczema, and when used under these circumstances should be pushed to the limit of tolerance.

Diet and hygiene are of importance. The former should be regulated with a view to elminating any disturbing factor that may proceed from the digestive tract. Highly seasoned, greasy food, salt fish and meats, cheese, pickles and other condiments should be interdicted. Sugars and starchy foods are to be avoided. Tea and coffee had best be discontinued, and alcohol forbidden.

Local Treatment. The local treatment of eczema is of the highest importance and calls for the exercise of much skill and patience to secure the desired result. The choice of remedies and strength of application must be regulated by the degree of inflammatory action, the stage at which the disease is encountered, and its extent. One of the guiding principles is to use sedation in the acute stages, stimulation in the chronic.

Water has a deleterious effect during periods of activity and should be used under this condition no more than is consistent with cleanliness. It removes the oil from the skin and retards keratinization. It may be made less harmful by the addition of starch, bran, oatmeal or borax. In the chronic states hot water is frequently of service in energizing an indolent process.

When the eczema is moist and oozing, lotions and powders are the remedies to be preferred, as unctuous substances do not adhere to a wet surface and may do actual harm.

Ointments and pastes should be reserved for subacute and chronic eczemas where exudation has abated.

Before beginning local treatment crusts must be removed with vaseline, olive oil, or potato or starch poultices.

Acute eczema. In acute eczema of the erythematous or vesicular type, lotions are used to advantage. The following are good examples of their class:

℞

Calamin.	
Zinc Oxid.,	āā ℥ij.
Acid Carbolic.,	℥j.
Aquæ Calcis,	℥ij.
Glycerin,	℥j.
Aquæ Rosæ ad,	℥viij.

M. Sig. Shake and apply locally every two or three hours.